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Textbook of Palliative Care

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Psychological symptoms

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Abstract

Psychological symptoms are highly prevalent in people requiring palliative care. They are much more challenging to elicit and more controversy exists about what is normal and what might require intervention than physical symptoms. There are significant issues in determining what is normal and what is not. Sadness, distress, anxiety and depression can co-exist and require careful assessment.

Management of psychological symptoms and conditions can broadly be considered in terms of non-pharmacological and pharmacological therapies; “the talking and the drug therapies.” These are not mutually exclusive and for people with limited energy, failing cognition and limited time some pragmatic decisions may be necessary. To be distressed and immobilised by emotion is not normal. Depression is not a normal part of dying. There should be discussion about the nature of psychological issues and conditions, explanation of common somatic symptoms and a plan for intervention and support.

The burden on the carer, both professional and personal, in such situations should not be under-estimated.

Key words

Psychological symptoms, anxiety, depression demoralisation

Psychological symptoms

Symptom control is a significant part of the healthcare interventions provided by clinicians for people facing the end of their lives. Physical symptoms are generally well recognised and have a considerable prevalence (e.g. lack of energy (73.4%), pain (63.1%), nausea (44.7%), lack of appetite (44.5%), constipation (33.6%), cough (29.4%) and shortness of breath (22.9%)).(Portnoy, Thaler et al. 1994) Psychological symptoms are much more challenging to elicit and more controversy exists about what is normal and what might require intervention. Symptoms such as anxiety and depression may not be as easily acknowledged, diagnosed or treated by patients, carers or healthcare providers.(Derogatis, Morrow et al. 1983, Razavi, Delvaux et al. 1990, Barraclough 1997, Dein 2000, Henderson, Andrews et al. 2000, Gilbody, House et al. 2001) For many the label of a “psychiatric” or “mental health” issue carries a strong stigma. Some would see serious risks associated with “unnecessary pathologising” what are possibly normal reactions.(Parker, Fletcher et al.) This can inhibit full assessment and the consideration and implementation of appropriate interventions to provide relief.

What is normal – sadness, distress, anxiety and depression

The diagnosis of an incurable illness is associated with an expected emotional response to the loss of well-being and to a potentially limited and altered future. Sadness, tearfulness, altered sleep and change in appetite and eating habits are a normal response to receipt of this information and the impending loss it conveys.(Zisook and Shear 2009) These symptoms constitute a grief reaction.(Kübler-Ross 1969, Periyakoil 2001, Grunfeld, Coyle et al. 2004) The symptoms of grief and sadness, as responses to such a situation, can be seen to be on a continuum with those of an anxiety and major depressive illness. Depression is not necessarily the inevitable response to such a situation. This raises the dilemma of defining thresholds(Chochinov, Wilson et al. 1994, Robinson and Crawford 2005) at which a diagnosis is made and what might be considered to be the “normal” reaction to considering the possible end of one’s own life. Emotions to death and dying and reactions to such information is modified by personal beliefs and cultural factors, particularly relating to what a person might believe occurs after they die. There are cross cultural and historical attitudes to such complex issues including belief in an after-life with perhaps heaven and hell, to a nihilism or sense of nothingness,. Kübler-Ross introduced the concept of different types of depression – a reactive and a preparatory depression – the latter being seen as a normal part of the dying process and something that should not be interrupted.(Kübler-Ross 1969) She believed that “an understanding person will have no difficulty in eliciting the cause [of the depression]”. This is not as easy as she has suggested but may help to explain why some clinicians feel inhibited or may fail to intervene in distress, anxiety, depression or even to assess systematically for psychological symptoms.

The person experience

It is always useful for healthcare providers to try to put themselves in the shoes of their patients or clients. It is all too easy to forget how foreign the environments are that we work within and how vulnerable our patients are. Not only are they being given bad news and

potentially life-threatening information but there are larger issues to consider. Not only are people trying to understand the problem and ask the obvious questions about what might be done to cure, control or modify the process, but there are physical symptoms to manage and changes in body function. There are multiple demands for healthcare appointments and relationships to navigate with multiple providers. The need for information, clear communication and a sense of some control in what feels like the uncontrollable all are aspects of the experience for most.

It is not surprising that there will be impacts on work and leisure. There will be disruption of home, social and financial arrangements. There are going to be changing roles and functions within the family. And in all of this most will be dealing with the understandable fear of loss of role, function, purpose and fear of death. And most would wish to maintain or find a new sense of meaning and purpose in life.

Distress

Psychological issues may present in many ways. Some people may express distress, depression or anxiety in terms of unrelieved physical symptoms rather than emotion. It may be that there is only limited mild intermittent distress, or it may be a severe persistent distress that can become an overwhelming anxiety. (National Comprehensive Cancer Network 2003) And there are questions about whether anxiety leads to depression or vice versa. And it is reasonable to consider that these issues are not simply binary, i.e. both can co-exist and feed into the expression of psychological distress and vary over time. Exploring a person's experience of their illness, understanding the context and meaning ascribed to that illness and the physical, social, emotional and spiritual influences and components of their distress are all vital to more fully assess and understand the person's experience. (Clayton, Hancock et al. 2007)

Demoralisation

Within palliative care literature, demoralisation as a syndrome has been proposed by Kissane et al (Kissane, Clarke et al. 2001) as having core features of hopelessness, loss of meaning, and existential distress. It is believed that this syndrome can be differentiated from depression and is recognizable in people facing the end of their lives. It is associated with chronic medical illness, disability, bodily disfigurement, fear of loss of dignity, social isolation, and feelings of greater dependency on others or the perception of being a burden.

Because of a sense of helplessness, those with the syndrome are thought to progress to a desire to die or to commit suicide. Treatment is aimed at relieving or alleviating the distress caused by this syndrome. The Cambridge dictionary (Cambridge University Press 2018) describes demoralisation as "having lost your confidence, enthusiasm, and hope." And also suggests feelings of sadness and unhappiness. Some alternative words and phrases have included "being down in the dumps, doleful, downhearted, miserable, morose and feeling wretched." These are powerful words and feelings.

Anxiety

Anxiety is a feeling of worry, nervousness, or unease about something with an uncertain outcome often with an associated strong concern that something unpleasant might happen.(CareSearch 2017) For people facing the end of their lives it would seem entirely reasonable that there is a fear or threat of separation and loss. It is common to hear people voice fears not only about death, but also about the dying process, the manner of dying, the course of the illness, and the impact on their family. It is important to ask about suicidal thoughts or impulses in a patient experiencing significant anxiety or depressive symptoms.(Hudson, Schofield et al. 2006) Anxiety can accompany a depressive disorder.

The challenge is to be able to broach these difficult but important conversations. This requires a willingness to ask questions, to make connection, to have advanced communication skills and be willing to listen. Some possible opening questions might be, 'What do you feel about everything that is happening to you?'; 'You seem (upset/anxious/depressed) today. Would you like to talk about how things are going?'

A full assessment requires specific questions about anxiety, depression and likely symptoms. An exploration of physical symptoms such as palpitations, nausea, dizziness, shortness of breath, trembling, sweating and diarrhoea is useful. Psychological symptoms may include feelings of apprehension, fear and dread. You should also consider treatment-related factors, drug-induced anxiety, drug withdrawal including alcohol, tobacco, other drugs and disease-related factors, such as poor control of pain, nausea, dyspnoea and hypoxia.(Palliative Care Expert Group:, Moulds R et al. 2016)

It is important to assess for a depressive disorder as this may be the underlying condition when anxiety is severe, and it does not respond to supportive measures.

Depression

Depression is a major health issue in Australia.(Wilhelm, Mitchell et al. 2003) There is a growing body of research about depression in palliative care populations and concern that it is a difficult and not particularly well-managed problem. This may relate to the inherent nature of depression but is possibly compounded by the difficulties of assessment and management in palliative populations, a group of people with many physical symptoms and the added burden of the existential issues associated with anticipating the end of life.

Depression has a significant and often unseen impact on the well-being and quality of life(Grassi, Indelli et al. 1996, Goldney, Fisher et al. 2000, Ruo, Rumsfeld et al. 2003, Smith, Gomm et al. 2003) of the people it affects and on those around them. However, the construct and definition of depression is difficult. It is poorly understood. The general public and even health professionals may have quite different and divergent concepts, understandings and beliefs about what depression is.(Ng, Crawford et al. 2013, Ng, Crawford et al. 2014, Ng, Crawford et al. 2014) The general public may consider crying, feeling sad, being melancholic or feeling "upset" or "down and blue" to be depression. Palliative care professionals are often untrained in psychological health assessment and management. They are likely to have varied and possibly inaccurate concepts about

psychological illness. A mental health professional diagnosis of a major depressive illness requires a constellation of specific symptoms that may include feelings of sadness and feeling “down and blue” that are pervasive and persistent.(World Health Organization 1993, American Psychiatric Association 2013) Symptoms are on a spectrum of severity and can extend to a psychotic illness with loss of contact with reality and with loss of hope for the present or the future. Even the diagnostic systems proposed by specialist psychological authorities vary in the symptom constructs that are described to make a diagnosis, and the instructions and advice offered may be difficult to interpret and implement.

Depression is a prevalent problem in our society.(Chochinov, Wilson et al. 1994, Hotopf, Chidgey et al. 2002, Lloyd-Williams and Riddleston 2002, Durkin, Kearney et al. 2003, Meyer, Sinnott et al. 2003) Depression is poorly recognised and poorly treated(Lloyd-Williams 1999, Wilson, Chochinov et al. 2000, Durkin, Kearney et al. 2003, Lloyd-Williams, Dennis et al. 2003, Lloyd-Williams, Spiller et al. 2003) within palliative care patients, causing increased suffering and hardship for these patients and their carers and families. Physical symptom control can be much more difficult to achieve in these patients.(Dinan 1999) Carers’ ability to support their depressed family member or friend may be diminished, at a time when there may be very little pleasure remaining in their lives. Interaction with and assistance from health care providers can be impeded, resulting in poorer health outcomes.(Spiegel 1996, DiMatteo, Lepper et al. 2000, Passik, Kirsh et al. 2002, Kelly, Burnett et al. 2003, Lin, Katon et al. 2003) Depressed patients are less likely to attend appointments.(DiMatteo, Lepper et al. 2000) They are likely to feel bad about themselves and to make people around them feel uncomfortable, further perpetuating their isolation. They are more likely to be seen as “bad” or “difficult” patients, further reinforcing these negative feelings.

In Australia, the current one month prevalence of major depression in the general population is 3-5%.(Wilhelm, Mitchell et al. 2003) This is similar to the reported prevalence in the United States of America and the United Kingdom.(Wilhelm, Mitchell et al. 2003) Depression is reported to be more common in the unemployed, smokers, and those having a medical condition,(Breitbart, Bruera et al. 1995, Block 2000) as well as being in mid-life,(Fredman, Weissman et al. 1988, Sorenson, Rutter et al. 1991, Blazer, Kessler et al. 1994) those previously married and in females.(Goldberg and Huxley 1992, Weissman, Bland et al. 1996) Depression is predicted to be one of the leading contributors to the burden of disease into the future.(Murray and Lopez 1996)

In the medically unwell, the assessment of depression is more problematic, and the prevalence is much more difficult to determine. In a systematic review of the prevalence of depression in patients with advanced disease, particularly advanced cancer and amongst mixed hospice populations, i.e. palliative care populations, Hotopf et al(Hotopf, Chidgey et al. 2002) found that depression was a common problem; however, the quality of research was poor. The prevalence of depression varied between 1% and 50%. This variation is likely to be because of small sample size, and large attrition and exclusion rates, due to deteriorating physical and mental function and death, and different definitions for making a diagnosis of depression. Many studies provided limited information about participants including demographic and clinical details and failed to provide “any data on the extent or severity of the participants’ disease and their survival.” The generally agreed prevalence of depression in the medically unwell and in palliative care populations is 25%.(Barraclough

1999) Depression in this population is greater in the young(Blazer, Kessler et al. 1994) and in some particular diseases (e.g. carcinoma of the pancreas).(Holland, Korzun et al. 1986) There have been studies of the interaction between asthma and diabetes with depression, showing that with increased physical symptoms there is also an increase in depression.(Goldney, Ruffin et al. 2003, Goldney, Phillips et al. 2004)

There are accepted systems for classifying the symptoms and signs required to make a diagnosis of depression.(World Health Organization 1993, American Psychiatric Association 2013) There is however no single universally agreed system to confirm such a diagnosis and no one objective measure. The “gold standard” for making a diagnosis remains a systematic, structured clinical interview followed by the judgement of a mental health professional. The two widely accepted classifications of mental illnesses are the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association(American Psychiatric Association 2013) and the International Classification of Diseases (ICD) developed by the World Health Organisation.(World Health Organization 1993) Many of the symptoms that might be considered may be on the continuum from normal variation to a clinical disease or condition. There is also possible overlap of symptom criteria with other known physical and psychological diseases and conditions. The diagnostic process requires the patient to have the physical, mental and psychological capability to participate. There are clearly potential and real barriers to the assessment and diagnosis of depression, particularly in terminal illness. See Table 1.

A DSM-5 diagnosis of a major depressive episode requires that five symptoms, which may include both psychological and somatic symptoms, be present during the same period and that one of these is either depressed affect or anhedonia.(American Psychiatric Association 2013) DSM-5 diagnostic criteria for a major depressive episode include somatic symptoms that are common amongst medically ill patients, such as fatigue, change in weight, altered sleep patterns and concentration. These somatic symptoms of depression may overlap with the symptoms of many medical illnesses. DSM-5 instructs doctors to exclude potential somatic symptoms of depression “when they are clearly attributable to another medical condition.”(American Psychiatric Association 2013) But this advice creates practical problems.(Peveler, Carson et al. 2006) For a population with a large number of “somatic symptoms,” this instruction is not as easily translated into practice as might be suggested. It is often impossible to determine the aetiology of symptoms. There is concern that including somatic symptoms of unknown aetiology may lead to over-diagnosing depression.(Ouslander 1982, Endicott 1984, Rapp and Vrana 1989, Kalichman, Rompa et al. 2000) Alternatives to DSM-5 and ICD-10 classifications of depression have been proposed to differentiate depression from symptoms of a wide range of medical conditions, including cancer,(Endicott 1984) Parkinson’s Disease,(Marsh, McDonald et al. 2006) dementia,(Vida, Des Rosiers et al. 1994) chronic pain(Wilson, Mikail et al. 2001) and generally for the elderly.(Rapp and Vrana 1989, Gallo and Rabins 1999) They include three approaches: “aetiological” (case-by-case or blanket exclusion from diagnostic criteria of symptoms judged likely to be due to medical illness or ageing); “inclusive” (inclusion of all symptoms regardless of aetiology); and “substitutive” (substitution of additional psychological symptoms for most or all somatic symptoms).(Endicott 1984, Cohen-Cole and Stoudemire 1987, Rapp and Vrana 1989, Kathol, Mutgi et al. 1990, Chochinov, Wilson et al. 1994)

Judging whether a symptom is “clearly and fully accounted for” by the patient’s medical condition may be impractical.

Ellis et al (Ellis, Robinson et al. 2006) compared the two extreme approaches that do not require this judgement, i.e. the inclusion of somatic symptoms regardless of aetiology (i.e. the DSM-5 guideline is ignored) and the exclusion of somatic symptoms which might be caused by the patient’s medical condition or ageing. Somatic symptoms regardless of their aetiology did not adversely affect the identification of patients who showed evidence of psychological distress warranting follow-up. In contrast, the exclusion of somatic symptoms potentially due to disease or ageing led to under-recognition of psychological distress. (Ellis, Robinson et al. 2006) Suggestions that somatic symptoms be excluded or substituted when assessing older and medically ill adults (Yesavage, Brink et al. 1982-1983, Bukberg, Penman et al. 1984, Rapp and Vrana 1989) were not supported. Whether somatic symptoms should be included, treated in a specific way or be excluded is still unclear and ultimately the decision must be left to the clinician and the individual situation.

There are barriers to effective management of depression in palliative care: recognition, diagnostic and treatment barriers related to patients, clinicians and health care systems. (Goldman, Nielsen et al. 1999) Patients create an important barrier to the recognition of depression by their failure to disclose psychological distress. (Hinton 1994) Reasons may include a belief that talk about emotions is a waste of doctors’ time, (Maguire 1985) that they are responsible for their own distress, (Maguire and Howell 1995) that depression is too common to be noteworthy, (Endicott 1984) and patient “stoicism”. (Endicott 1984) Indeed, patients may actively deny their psychological distress in order to avoid the stigma associated with psychological disorders, because they believe depression is a sign of weakness, to avoid causing additional worry to their families, or because they fear being seen as ungrateful for the efforts of their family and clinicians. (Endicott 1984) Patient disclosure is also influenced by clinicians’ conscious or unconscious use of tactics that limit the expression of emotional distress. (Maguire 1985)

Clinicians also directly contribute several barriers to the recognition and diagnosis of depression. Clinicians may have low motivation to identify patients with depression. (Wilson, Chochinov et al. 2000) Depression can be difficult to detect accurately. It is a syndromic disorder: no biological markers can be used to identify it. Diagnosis relies on emotions, behaviours, and cognitions that overlap those reported by patients with other psychological disorders and patients with no psychological disorder. As a result, it is known that symptoms of depression may not be recognised accurately by day care staff, (McIntyre 1982) nurses, (McDonald, Passik et al. 1999, Passik, Donaghy et al. 2000, Meyer, Sinnot et al. 2003, Pautex, Berger et al. 2003) or doctors (Passik, Dugan et al. 1998, Passik, Donaghy et al. 2000, Durkin, Kearney et al. 2003, Pautex, Berger et al. 2003) who do not have specialist mental health training. Nurses recruited to palliative care services are rarely required to have mental health training and their continuing education generally fails to focus on these issues. (Lloyd-Williams and Payne 2003)

Assessment

A careful and considered history is always the first step in assessment.(Butow, Price et al. 2015) The clinician should not be frightened of asking difficult questions. Not exploring a situation fully will lead to misunderstandings, assumptions and ultimately poor management. A diagnosis of major depression is based on having a depressed mood that cannot be lightened, loss of pleasure or interest, even within the limitations of the illness, an excessive feeling of being a burden to others, accompanied by a sense of worthlessness or low self-esteem, of fearfulness and/or anxiety and avoiding others or withdrawal. There may be brooding or excessive guilt and/or remorse, a pervasive sense of hopelessness or helplessness, a persistent desire for death, or suicidal ideation with prominent and persistent insomnia and excessive irritability.

Asking a person about their mood and exploring their thoughts including specifically asking about suicidal ideation or intent are not inherently dangerous. Indeed, it is indefensible to avoid these issues. It is unreasonable to fear that raising these issues might “give the person ideas.” This is not true. It is important however to explore the person’s thoughts about death and desire to actively end their life, the degree of planning, and access to means and intent to die.(Hudson, Schofield et al. 2006) Individual jurisdictions will have different thresholds and legal requirements for clinicians to ensure a person’s safety. To deprive a person of their liberty is a serious responsibility but at times this may be indicated and even more challenging when the person in consideration has a serious and potentially life-limiting illness.

There are many questionnaires and screening tools that have been proposed to assist in making the diagnosis of a psychological disorder or condition.(Beck and Beck 1972, Chochinov, Wilson et al. 1997, Kramer 1999, Hickie, Davenport et al. 2001, Lloyd-Williams 2001, Akizuki, Akechi et al. 2003, Arroll, Khin et al. 2003, Crawford and Robinson 2008) The gold standard is a structured clinical interview. Commonly used screening instruments may only be uni-dimensional considering “anxiety” as a single concept or “depression” or “depressed affect” such as using a visual analogue scale. That anxiety and depression are commonly co-existent is perhaps evidenced by the popularity of the Hospital Anxiety and Depression Scale (HADS) that is commonly used in clinical and research practice.(Kramer 1999)

The impact of treatment-related factors, drug-induced depression, drug withdrawal including alcohol, tobacco, other drugs(Passik and Theobald 2000) and disease-related factors, severe uncontrolled symptoms, or fear of symptoms such as pain should be part of the assessment. Important factors can include a past personal or family history of suicide attempt, cognitive problems (e.g. delirium) and any psychotic symptoms (e.g. hallucinations, delusions). An important part of the assessment should also include the person’s level of isolation and social and family support.

Management

Management of psychological symptoms and conditions can broadly be considered in terms of non-pharmacological and pharmacological therapies; “the talking and the drug

therapies.” These are not mutually exclusive and for people with limited energy, failing cognition and limited time some pragmatic decisions may be necessary.

The power of the clinician’s and the clinical team’s therapeutic relationship should never be under-estimated.(Marziali and Alexander 1991) To provide clear information and explanation of what is happening physically and psychologically can be reassuring for many to assist in coping with the personal and social impact of disease. Supportive counselling and just being willing to exploring the patient's distress, fears and concerns and to promote a realistic hope should not be minimised. Dealing with physical symptoms and trying to address social and financial concerns can offer significant reduction of distress. Promoting communication with and support from others and by involving family and carers in care of the patient are useful strategies. Helping people to remember and gather the emotional resources that have sustained them through their lives before this crisis is a useful strategy for many. These are in essence attempts to try to reframe the situation and to consider strategies that assist in finding meaning and purpose.

Cognitive and other behavioural therapies can provide benefit(Coull and Morris 2011) but may not be readily accessible or people may not have sufficient energy, time and clear cognition to participate. Some of the nurturing therapies so well-known in hospice care can provide a place of safety and relief as well. Life review and making meaning, whether in formal Dignity therapy,(Chochinov 2002) structured or informal biography services or even reviewing the family photographs may all be useful. Therapies to induce relaxation and some sense of peace should be considered. Some gain benefit with massage, aromatherapy, visualisation and music therapies.(Hilliard 2001, Krout 2001, Demmer 2004, Kyle 2006, Ernst 2009)

Medication to moderate symptoms and to improve mood should be considered and if appropriate introduced early. Antidepressants have delay in maximum onset of therapeutic benefit. Many people are commenced on such medications when there is insufficient time to gain real and meaningful benefit.(Lloyd-Williams, Friedman et al. 1999) There is evidence that anything other than very short-term use of benzodiazepines is a useful strategy for the longer-term management of anxiety.(Palliative Care Expert Group:, Moulds R et al. 2016) Benzodiazepine medications with very short half-lives are particularly problematic particularly at the end of life. The clinical situation, the likely prognosis and the intensity of the symptoms will all influence decisions. Antidepressants are likely to offer better long term relief of anxiety. It is worth considering the full constellation of symptoms and trying to maximise benefit by employing medications that might assist other symptoms such as disturbed sleep and neuropathic pain. A trial of antidepressants for those with symptoms highly suggestive of a major depressive disorder should always be considered early. Choice about individual medicines will be guided by prescriber experience, confidence, route of administration, likely prognosis and assessment of possible side-effects and their likely impact on the person’s quality of life.

And it can be argued that for the management of pain, most clinicians would initiate therapies even if there is incomplete understanding of the full aetiology of the pathophysiology of the symptom. For psychological symptoms it may be equally reasonable to commence interventions to assist in ameliorating the symptom, even in the absence of a

full and clear diagnosis. The best way to support someone with a major psychological issue is to provide a coordinated interdisciplinary approach that is provided with professionals with different skills, working together to form a cohesive and consistent framework for the person and their family.

What does it all mean?

To be distressed and immobilised by emotion is not normal. Depression is not a normal part of dying. One must not ignore or avoid discussing these important issues, but help people to explore, if they wish, the meaning of what is happening and to assist in formulating a plan of support and intervention. To feel abandoned in such a situation would be unthinkable.

The management of psychological issues particularly for people facing the likely end of their life is complex. It may be quite daunting. But this should not allow any to avoid assessing and commencing a therapeutic plan – be they inexperienced or experienced clinicians. Consider what resources are available within your network to provide advice and consider what further assessment and interventions might be available to assist you and your patients.

It is important to try to provide continuity of care and emotional support, to understand the patient's concerns and needs and those of their family. There should be discussion about the nature of psychological issues and conditions, explanation of common somatic symptoms and a plan for intervention and support. Medications are important but not the only “answer.” Adverse effects on cognition, alertness, possibly mood and behaviour should be assessed. Anti-depressants may assist both anxiety and depression, with or without judicious, short-term benzodiazepine use. If they are likely to provide benefit, then prescription is better earlier rather than later.

The burden on the carer, both professional and personal, in such situations should not be under-estimated. Those providing personal care are likely to require extra support as well. Clinicians should not under-estimate their own personal cost of supporting patients in these circumstances. The support of a team is useful and remembering to access the strategies for personal well-being is vital.

“Slowly, I learn about the importance of powerlessness. I experience it in my own life and live with it in my work. The secret is not to be afraid of it – not to run away. The dying know we are not God....all they ask is that we do not desert them.”(Cassidy 1991)

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Table 1 Comparison of symptoms assessed by DSM-5 and ICD-10

	DSM-5	ICD-10	
Need ONE of these	<i>Depressed affect</i>	<i>Depressed affect</i>	Need TWO of these
	<i>Anhedonia</i>	<i>Anhedonia</i>	
	Fatigue	<i>Fatigue</i>	
Need FOUR of these symptoms	Weight loss or change in appetite	Change in appetite	Need FOUR of these symptoms
	Insomnia or hypersomnia	Sleep disturbance	
	Psychomotor agitation or retardation	Psychomotor agitation or retardation	
	Worthlessness or guilt	Guilt	
	Concentration problems or indecisiveness	Concentration or thinking problems	
	Recurrent thoughts of death or suicide ideation	Recurrent thoughts of death or suicide	